Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FONDREN ORTHOPEDIC GOUP LLP
7401 SOUTH MAIN
HOUSTON TX 77030-4509

Respondent Name
INDEMNITY INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-13-0685-01

MFDR Date Received
NOVEMBER 13, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was process and CPT code 27658 was denied stating precertification exceeded. However that is incorrect auth mentions ankle peroneous repair which is what was done. There are 2 peroneous in the ankle and the statement 'ankle peroneous' includes both. I have attached a copy of the authorization as well for supporting documentation."

Amount in Dispute: $379.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There were four procedure codes that were not included in the pre-authorization for this surgery, and were therefore denied accordingly. The request came in with the CPT codes and that is what was reviewed for medical necessity. The provider billed four additional codes when they submitted their billing which were not included on the original request. The provider specifically mentioned one occurrence of the code 27658 in their dispute, but there was another 27658 code along with the 27676 and 28120 that were also denied for authorization."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201329, Austin TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 30, 2012	CPT Code 27658	$379.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 198 – Precertification/authorization exceeded

- MA04 – Number of Occurrences on Authorization record has been exceeded.

Issues

1. Did the requestor obtain preauthorization for the service in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(f) states in pertinent part, "The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the: (2)specific health care listed in subsection (p) or (q) of this section." Review of the documentation submitted by the requestor finds no documentation that supports that CPT Code 27658 was included with the request for preauthorization. The requestor did submit the preauthorization approval which shows CPT Codes 27658, 27695 and 27691 were preauthorized.
2. Review of the submitted documentation finds that the requestor has not supported the service in dispute was preauthorized; therefore no reimbursement is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 27, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.